



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 03-May-2018 | Report No: PIDISDSA24461

**BASIC INFORMATION****A. Basic Project Data**

| | | | |
|--|--|---|---|
| Country Egypt, Arab Republic of | Project ID P167000 | Project Name Transforming Egypt's Healthcare System Project | Parent Project ID (if any) |
| Region MIDDLE EAST AND NORTH AFRICA | Estimated Appraisal Date 24-Apr-2018 | Estimated Board Date 28-Jun-2018 | Practice Area (Lead) Health, Nutrition & Population |
| Financing Instrument Investment Project Financing | Borrower(s) Ministry of Investment and International Cooperation | Implementing Agency Ministry of Health and Population | |

Proposed Development Objective(s)

The proposed Project Development Objective is to (i) improve the quality of primary and secondary health care services, (ii) enhance demand for health and family planning services, and (iii) support the prevention and control of Hepatitis C.

Components

Strengthen Primary Healthcare, Family Planning and Community Activities
Strengthen Secondary Level Care
Institutional Capacity Building and Project Management
Contingency Emergency and Response Component (CERC)

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

| | |
|---------------------------|--------|
| Total Project Cost | 992.50 |
| Total Financing | 992.50 |
| of which IBRD/IDA | 530.00 |
| Financing Gap | 0.00 |

DETAILS**World Bank Group Financing**

| | |
|--|--------|
| International Bank for Reconstruction and Development (IBRD) | 530.00 |
|--|--------|



Non-World Bank Group Financing

| | |
|---------------------|--------|
| Counterpart Funding | 462.50 |
| Borrower | 462.50 |

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the team to appraise and negotiate



B. Introduction and Context



Country Context

- 1. Egypt has adopted a bold and transformative reform program to restore macroeconomic stability.** Egypt is a lower-middle-income country with a population of 96 million (Census 2016) and a gross domestic product (GDP) per capita of US\$2,048. Following a build-up of macroeconomic imbalances that had resulted in declining growth, rising debt, and a widening current account deficit, the Egyptian authorities undertook decisive policy actions since the launch of the reform program in 2016. In November 2016, the currency was floated eliminating the overvaluation and the shortage in foreign exchange shortage, and the authorities moved forward with important fiscal consolidation measures, including significant energy subsidy reforms, and introducing a value-added tax (VAT). This is in addition to critical pieces of legislation necessary to strengthen the business climate, attract investments, and promote growth, including the adoption of an industrial licensing law, a new investment and insolvency law. The government's reform program is widely endorsed, including through the World Bank's programmatic DPF series (FY16-18) and the IMF's three-year Extended Fund Facility approved in November 2016 in the amount of estimated US\$12 billion.
- 2. Real GDP grew by 4.2% in fiscal year 2016/17, in line with 4.3% the year before, despite the fiscal consolidation efforts.** Furthermore, growth accelerated to 5.2% in the first half of FY2017/18, compared to 3.6% in the same period of the previous year. Medium-term growth prospects are favorable, provided growth-friendly policies and reforms continue to be implemented. Downside risks include slower implementation of reforms, which would undermine fiscal sustainability and private investment. Annual headline inflation has fallen to 14.4% in February 2018, from a peak of 33% in July 2017. The rapid decline in inflation over the past six months reflects the unwinding impact of the steep currency depreciation, hikes in administered prices and the introduction of VAT.
- 3. While the economy is recovering and macroeconomic imbalances are starting to narrow, social conditions remain challenging.** Poverty rates, based on national poverty thresholds, place about a third of the population below the poverty line in 2015. Regional income disparities are an enduring characteristic, with Upper Rural Egypt lagging other regions. The unemployment rate is 12% (at end-FY2016/17), a decrease from 12.5% the year before, while the youth unemployment rate is 25.7%. The government is strengthening social safety nets through the expansion of cash transfer schemes and increases in social pensions and food subsidy allocations. Although Egypt has made significant strides in human development in the areas of child mortality, life expectancy, primary and secondary school enrollment and literacy rates, there are persistent challenges with large inequalities in access to and quality of basic social services.
- 4. Promoting human development is one of three priorities under Egypt Vision 2030.** Egypt Vision 2030 was developed in 2015 as a national participatory effort coordinated by the Ministry of Planning and Administrative Reform. It provides a roadmap for inclusive development and for maximizing competitive advantages to achieve the aspirations of Egyptians for a dignified and decent life. It comprises: (i) an economic dimension, which includes economic development, energy, knowledge, innovation and scientific research, transparency and efficient government institutions; (ii) a social dimension, which includes social justice, health, education and training, and culture; and, (iii) an environment dimension, which includes environmental and urban development. Egypt Vision 2030 emphasizes that improvements in health outcomes will contribute significantly to Egypt's social transformation over the coming 12 years.

Sectoral and Institutional Context

- 5. Despite long-term improvements, the rate of progress on health outcomes in Egypt is slowing.** Since 1990, Egypt has achieved significant improvements in key health indicators. Maternal mortality declined from 106 to 33 deaths per 100,000 live births, and infant mortality has fallen from 60 to 20 deaths per 1,000 births (World Bank, 2015). Despite these improvements, regional disparities persist, and data suggest the rate of progress on indicators is slowing (DHS



2014). Life expectancy, although having increased from 66 to 71 years over that period, remains below the MENA average of 73 years.

6. **Concurrently, demographic pressures are rising.** The total fertility rate has increased from 3 to 3.5 births per women since 1990, contributing to rapid population growth. Egypt's population surpassed 100 million in 2017 and is expected to reach 128 million by 2030 and 150 million by 2050 (UN Population Projections). The government has warned that the rapidly growing population represents a major threat to development and has encouraged uptake of family planning, particularly in rural areas.¹ However, use of family planning by married Egyptian women has plateaued since 2008 (DHS 2017), the rate of long-term use has declined, and 3 in 10 users of family planning in Egypt stop using a method within a year of starting. According to the 2015 Egypt Health Information Survey, although most women have basic knowledge of common contraception methods, there is still a strong preference for larger families, particularly in Upper Egypt, among those with lower educational backgrounds, and among men more than women.

7. **Egypt's health sector is being challenged by disease-specific problems, particularly Hepatitis C.** Egypt has the highest prevalence chronic Hepatitis C Virus in the world; nearly 10% of Egypt's adult population (some 4.5 million people) is infected.² Many infections occurred decades ago, the result of poorly sterilized needles used as a part of national schistosomiasis treatment campaign, and are now leading to significant complications and deaths. Over the past decade, evidence suggests unsafe blood transfusions and improper infection control measures within healthcare facilities as the major route of the spread of infection. About 40,000 Egyptians die of Hep C every year, making it the country's third leading cause of death after heart disease and cerebrovascular disease. Moreover, roughly 150,000 new infections occur annually, mostly due to poor medical safety and hygiene, including blood transfusions. The prevalence is significantly higher among adults above the age of 40, the poor, and those living in rural areas. Hep C costs Egypt more than US\$400 million annually in direct costs, and total spending is projected to reach US\$4 billion by 2030 (World Bank 2017).

8. **Egypt is also facing a mounting burden of non-communicable diseases, driven by poorly controlled risk factors. NCDs account for an estimated 82% of all deaths and 67% of premature deaths in Egypt.**³ Since 2005, deaths from ischemic heart disease and cerebrovascular disease, the leading two causes of death, have increased substantially, with nearly half of those attributable to high blood pressure, based upon global estimates.⁴ Deaths from diabetes, the sixth-leading cause of death, have increased more than 50%, driven largely by obesity; Egypt has the highest obesity rate among the world's 20 most populous countries (GBD 2017). The economic impact of diabetes alone, estimated at US\$1.3 billion in 2010, is expected to double by 2030, and chronic conditions have been found to cause productivity losses equivalent to 12% of Egypt's GDP.⁵

9. **The Egyptian health system is not positioned to deliver high-quality health services to meet the most pressing needs of its population.** Although more than 95% of Egypt's population lives within 5 kilometers of a health facility, 6 the quality of care at these facilities is often poor, leading to low utilization and reduced health benefits. Medication

1 <https://www.reuters.com/article/us-egypt-population/egypt-promotes-birth-control-to-fight-rapid-population-growth-idUSKCN1BA153>

2 Egypt Demographic and Health Survey (2009)

3 IHME, (2016).

4 World Health Organization. 'Global health risks', The World Health Report 2004. WHO, Geneva, Switzerland. 2004.

5 Rocco L, Tanabe K, Suhrcke M, Fumagalli E (2011): Chronic Diseases and Labor Market Outcomes in Egypt. Policy Research Working Paper 5575. Washington DC: World Bank.

6 El-Zanaty F, et al. Egypt Demographic and Health Survey (2014). Cairo and Maryland: Ministry of Health and Population, the DHS Program, ICF International; 2014. [Internet]; Available from: <http://dhsprogram.com/pubs/pdf/PR54/PR54.pdf>; Van Wheel (2018), Primary healthcare policy implementation in the Eastern Mediterranean region: experiences of six countries, Eur J Gen Practice, 24(1).



stock outs, lack of updated and enforced clinical guidelines for managing chronic diseases, and limited specialists have been widely reported (World Bank 2010, 2015). Pharmaceutical supply chains are outdated and inefficient, and primary health clinics and hospitals are often ill-equipped to respond to the real needs of the population in their catchments areas. Basic safety issues remain a major concern: Although the National Blood Transfusion Center (NBTC) is responsible for ensuring adequate safe blood supplies, financial constraints have limited it from adopting modern technologies (e.g. nucleic acid tests) that reduce the risk of infection with Hep C and other bloodborne diseases. Although the government has developed quality accreditation standards for PHCs and hospitals based on international guidelines, adoption has been patchy and only project-dependent, owing to the lack of financing and hitherto unclear need for accreditation.

10. **Moreover, concerns about poor quality lead almost half of patients to seek care in private clinics and hospitals, where they incur higher out-of-pocket costs (OOP) and are at risk of being pushed into poverty (World Bank 2015).** Although an estimated 60% of Egyptians have health insurance through the government's Health Insurance Organization, fewer than a quarter of households use this insurance, due in large part to their concerns about the quality of care at government facilities.⁷ Moreover, vulnerable groups, including informal sector workers, the poor, and dependents, are not covered. As a result, use of private sector services is common, and OOP payments in Egypt have remained fixed at 61% of total health spending over the past decade, more than double the MENA average (World Bank 2015, 2016). These payments show significant inequities by income, gender, and geography. Egypt's poorest households spend the largest percent (21%) of their income on healthcare, leading to significant financial hardship,⁸ and nearly 7% of households are pushed into poverty each year due to catastrophic health expenditures.⁹ Households in rural areas and those with family members with a chronic condition are more likely to suffer catastrophic health needs.¹⁰

11. **The delivery of high-quality services is further limited by lack of patient education and demand, poor integration of care, and need for gender-tailored approaches.** Household surveys in Egypt have shown high rates of uncontrolled or undiagnosed chronic conditions, as well as poor community awareness about the risk of complications. Hep C is a particularly dramatic example, as several million Egyptians are infected but lack symptoms or a diagnosis that would prompt them to seek care. NCDs show low care-seeking as well. Spending on diabetes in Egypt is among the lowest in the MENA region, suggesting that many patients forego medications and consultations (IDF Atlas, 2013), and referral networks to ensure diagnosis, follow-up, and appropriate management are lacking. A 2013 study showed that only 6% of Egyptians in need of outpatient care go to public PHC facilities; most prefer private facilities. Only about a quarter of diabetics in Egypt had good medication adherence, and other research has shown a higher prevalence of complications (e.g. diabetic retinopathy) than global counterparts. Routine community outreach through mass media and public health campaigns also appears limited. Fewer than a quarter of married women report having seen information on family planning on television or in public spaces (EHIS 2015). Gender differences in disease burdens and needs must also be acknowledged. Nearly half of Egyptian women who would prefer a female doctor are treated by a male, likely limiting their level of comfort discussing sensitive matters and subsequent uptake of family planning (World Bank 2015). Women in Egypt are also more likely to be uninsured, illiterate, and have risk factors for NCDs, including obesity and hypertension, raising the need for targeted outreach approaches.

12. **Addressing Egypt's major health challenges and achieving broader development goals will require reorienting Egypt's health system toward delivering higher quality care.** Sustainable Development Goal (SDG) 3 calls upon countries to achieve universal health coverage by 2030, including ensuring access to quality essential health services

⁷ Rashad AS, Sharaf MF. Catastrophic and Impoverishing Effects of Out-of-Pocket Health Expenditure: New Evidence from Egypt. *American Journal of Economics*, 2015; 5(5): 526-533.

⁸ Egypt Household Health Expenditure and Utilization Survey (2011)

⁹ The World Bank, WHO PAYS? Out-of-Pocket Health Spending and Equity Implications in the Middle East and North Africa. (2010)

¹⁰ See Rashad and Sharaf (2015).



that provide effective coverage and improved health outcomes. Given Egypt’s burden of chronic and complex conditions, achieving this goal will require a health system that is much more responsive to current population needs. Reflecting current thinking around quality improvement, this shift toward higher quality care will need to ensure not only that the appropriate “structures” (including facility infrastructure, medicines, staffing, etc.) are in place, but also that technical processes and user experiences, as well as the organizational and management structures supporting them, are improved to deliver better outcomes.

13. **To address these challenges, the Government of Egypt (GoE) has identified universal health coverage (UHC), quality improvement, and specific disease burdens as national priorities, and embarked upon social health insurance reform and other initiatives.** In December 2017, the GOE passed a landmark Comprehensive Health Insurance (CHI) law to accelerate progress towards UHC. Under the new law, which will be funded through taxes, employer premiums, and subscription fees (with subsidies for the poorest Egyptians), the government will expand insurance coverage to an additional 30% of the population, including those who are unable to pay. The new system will be rolled-out in 6 phases over a 15-year period, with implementation starting in July 2018. The new law is expected to raise demand not only for services in general but also for higher quality: It will require public facilities to meet international accreditation standards (previously voluntary), and family health physicians will serve as gate-keepers for referrals to accredited facilities. In addition to the SHI law, the GoE has also recently adopted high-profile policies targeting the country’s key disease burdens, including the passage of a 2015 presidential mandate requiring Hepatitis C screening and a new national strategy, Operation Lifeline, to address high fertility rates and family planning needs, particularly in rural areas.

Table 1. Timeline for the roll out of the Comprehensive Health Insurance nation-wide in six phases

| Phase | Period | Governorates |
|-------|-------------|--|
| 1 | 2018 – 2020 | Ismailia, Port Said, Suez, South Sinai and North Sinai |
| 2 | 2021 – 2023 | Aswan, Luxor, Matrouh, Qena and Red Sea |
| 3 | 2024 – 2026 | Alexandria, Beheira, Damietta, Kafr Elsheikh and Sohag |
| 4 | 2027 – 2028 | Assiut, Beni Suef, Fayoum, Minya and New Valley |
| 5 | 2029 – 2030 | Dakahlia, Gharbia, Menoufia and Sharqia |
| 6 | 2031 – 2032 | Greater Cairo (Cairo, Giza & Qalyubia) |

14. **Given the importance of community outreach and awareness, the GoE has also taken steps to strengthen the role of community health workers (CHWs). Egypt’s CHW program (Raedat refiyat), created in 1994, currently supports more than 14,000 personnel under the MOHP and has achieved relatively good geographic coverage.** However, the program faces several challenges, including a need for more workers, stronger presence in many governorates, broader scope of counseling, and more formalized relations with public, private, and NGO sectors to improve referrals and awareness activities. In recognition of the pivotal role of CHWs, the MOHP has recently launched a national strategy for incorporating CHWs within the health system. The strategy serves as a framework and guide to improve CHWs’ capacity to drive behavior change and strengthen links between communities and the health system. The strategy also emphasizes the importance of the CHW program adopting new policies including: (i) developing technical protocols; (ii) gaining political support for CHW activities and media awareness campaigns; (iii) improving coordination among CHWs and public, private, and NGO sectors around awareness activities; and (iv) supporting the institutional and financial sustainability of CHW program services.

Bank Engagement



15. **The Bank's recently completed Egypt health project (Healthcare Quality Improvement Project- HQIP) provides a roadmap for the scale up of healthcare quality improvement.** Egypt has undertaken intermittent quality improvement efforts since the 1990s, but progress was significantly galvanized under the HQIP project, which focused on improving the quality of primary health care (PHC) services offered in Egypt's most vulnerable villages. More than 1,000 facilities successfully implemented quality improvement plans, including upgrading equipment and supplies, procuring medicines, and training health workers on clinical guidelines. The MOHP's supervision capacity was strengthened so it could carry out routine facility audits to ensure guidelines are followed, and almost 700 facilities were officially accredited. The end-line client survey showed a 30% improvement in patient satisfaction at project targeted facilities between 2016-2017. These results offer a framework for how such work could be scaled-up in Egypt.

16. **The HQIP also supported the GoE in launching its Hep C elimination program, which has achieved remarkable progress thus far and helped position Egypt as a global leader on Hep C elimination.** In recent years, the country has markedly lowered the costs for new Hep C treatments known as direct-acting antiviral agents (DAAs), which carry a roughly 96% cure rate. Approximately 5 million Egyptians have been screened and 1.6 million people treated. Also, the MOHP has developed a national electronic registry of screened patients. Nearly a third of these screenings were financed by the Bank in the first six months of 2017 under HQIP. Critically, these screenings were largely organized through PHCs, highlighting the central role of primary care in tackling this disease. However, significant challenges remain: the GoE has determined it still needs to screen an estimated 43 million people and treat an estimated 4 million infected patients to reach its elimination goal, and prevention activities, including ensuring a safe blood supply, need to be strengthened to avoid new infections. Doing so will require additional resources for (i) expanding the screening program through the PHC level and community outreach; (ii) ensuring the delivery of quality, affordable treatment; and (iii) making critical investments in other support services at the secondary level hospitals, medicine supply chains, blood banks, etc.

17. **The World Bank Team is proactively engaging Development Partners (DPs) to ensure consistency and harmonization in responding to the financial and technical needs of the MOHP.** Although many development partners contribute to Egypt's health sector, coordination has often been weak, leading to isolated vertical programming rather than a comprehensive, consistent package of services. As part of the Bank's engagement, it seeks to reduce rather than exacerbate these challenges. This includes regular bilateral and collective meetings with key DPs such as the UNICEF, UNFPA, WHO, and other partners. Overall, there is scope for DP support to be better coordinated through the GoE, to align available financial and technical assistance to the National Health Plan, and to harmonize all the efforts to ensure complementarity, reduce duplication, and support government priorities. Major partners include: (i) WHO in the areas of health insurance, infection control, disease surveillance, and management of NCDs; (ii) UNICEF in nutrition and primary healthcare; (iii) UNFPA in family planning, population issues and maternal health (through an EU grant of US\$ 27 million) focusing on supply side interventions; (iv) USAID in a US\$ 24 multi-phased support to the supply side of family planning and population activities and CHWs (US\$ 5 million); (v) AFD in boosting service provision especially in the delta region (€31 million) and raising awareness of the new Health Insurance system in partnership with MOF (€ 2 million); and (vi) EU in improving quality of health services (€120 million) and family and population grants to UNFPA. Other Bilateral funds (especially from the GCC) offer support to the hospital and primary care infrastructure expansion and rehabilitation. The proposed project will be a catalyst in this process by aligning with the overall government reform agenda, complementing ongoing activities and filling gaps (e.g. demand generation), and coordinating closely with all DPs in the health sector.



C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

18. The proposed Project Development Objective is to (i) improve the quality of primary and secondary health care services, (ii) enhance demand for health and family planning services, and (iii) support the prevention and control of Hepatitis C.

Key Results

19. The following seven PDO indicators will be used to measure each part of the PDO. In addition, there are also fifteen Intermediate outcome indicators (IO) to measure changes in the quality improvement process as well as in other specific areas supported under the project, including one Corporate Results Indicator (See Results Framework).

20. The indicators related to improvements in quality of PHCs and hospitals reflect 3 dimensions of quality (see detailed description under project components below): (a) the foundational dimensions necessary to provide care (PDO indicators ii and iv); (b) process/clinical content of care (PDO indicator iii and v); and (c) results from the improved quality of services (PDO indicator i).

Table 2. PDO Indicators

| <i>Elements of the PDO</i> | <i>PDO Indicators</i> |
|------------------------------------|---|
| Improved quality of PHC | Number of PHCs passing Quality of Services Index composite indicators list Percentage improvement in the average quality of clinical care score at all targeted PHCs, measured through independent direct observations |
| Improved quality of secondary care | Percentage improvement in the average quality of clinical care score at all targeted hospitals measured through independent direct observations |
| Improve family planning services | Contraceptive prevalence rate |
| Prevention and control of Hep C | Number of people screened for Viral Hepatitis C Percentage of people who received treatment for Hepatitis C who have taken the final confirmation test for sustained virological response (SVR) using a random sampling methodology Percentage of blood units dispensed at MOHP hospitals that have been screened utilizing the Nucleic Acid Test (NAT) |

D. Project Description

21. **Component 1: Strengthen Primary Healthcare, Family Planning and Community activities (US\$247.4 million total estimated cost).** This component will mainly finance results using Disbursement-Linked Indicators (DLIs) achieved and verified by an independent verification agency (IVA) although there are specific activities under this component which will also be financed using the regular IPF disbursement method. Progress against each DLI will be tracked



through measuring achievement against Disbursement-Linked Results (DLRs), each of which will be independently verified prior to disbursements being made against each DLR. Details on the DLIs and DLRs are provided below under each component and under the project costs and financing section below as well as in Annex 1 (DLI Matrix). This component will support the following:

22. **Sub-component 1.1: Providing for quality services at PHCs (US\$69.5 million).** This sub-component will strengthen improvements in selected 600 PHCs in 9 governorates (Ismailia, Suez, North Sinai, South Sinai, Qena, Luxor, Aswan, Alexandria and Matrouh). The goal would be to: (a) update and modernize the quality framework for MOHP through updating the national accreditation guidelines which will subsequently be used nationally to improve PHC quality across Egypt, conduct a mapping and a needs assessment exercise of PHC services in the 9 governorates, and ensure GRM mechanisms and district level management are both enabled; (b) ensure the quality of services provided by using a quality index which will measure selected output and intermediate level results; (c) ensure a demonstrable improvement in the quality of the clinical level services offered to patients as evidenced through independent direct monitoring scorecards; and (d) accredit targeted PHCs using quality accreditation standards outlined in the updated National Egyptian Accreditation Guidelines which will provide them with contractual eligibility with the new CHIS. This will lead to enhanced quality of services, including clinical consultations, nutrition services, family planning, routine public health programs, mental health, infection control, strengthening district level management procedures, referral services, and patient education.

The following four DLIs will be used to achieve the results under this sub-component, as follows:

23. **DLI 1: Development of Quality tools and mechanisms (US\$4 million).** This DLI will ensure that the needed foundational studies and systems required for improving further quality services at the PHC level are achieved. Those would include the completion of the following: (i) Two PHC level needs assessment studies that demonstrate the actual needs of the target PHCs. One would be for facilities that have never been accredited before and another for those facilities that will lose their previous accreditation status during project duration; (ii) Service mapping exercise that would set the new envisioned model for allocating different resources and services to population needs; and (iii) Develop and officially issue the revised and updated National Egyptian Accreditation Guidelines that will be used for accreditation purposes under the project support.

24. **DLI 2: Grievances addressed in project target facilities in accordance with the revised GRM Manual issued in 2017 (US\$3 million).** This will include the dissemination of the GRM manual in the 9 governorates and training of staff at the PHC and district level and gradually improving the citizen feedback system, increasing the number of grievances addressed in project target governorates.

25. **DLI 3: Strengthening decentralized management (US\$2.5 million).** This DLI will incentivize the training of district level management in project target districts on fiduciary practices that would strengthen their capacity towards better management of local resources. Specifically, this DLI will track the percent of districts participating in the Project certified for having completed fiduciary training. This DLI will be critical in ensuring more effective use of resources, particularly in view of the results based nature of the project.

26. **DLI 4: Improvement of PHC quality of services (US\$60 million).** This DLI will support targeted PHCs to attain incremental levels of higher quality services in terms of process, patient perspective and system perspective. All target facilities will be assessed for results using a 2-level approach. First, facilities will have to score at least 80% of the composite Quality of Services Indicators (QSI) that measure selected processes, output and intermediate outcome functional indicators (see Annex 2). The QSI has been closely designed with UNICEF. Secondly, after passing the QSI



composite indicators through a rigorous verification process conducted by the IVA, PHCs will have to work towards reaching accreditation certification through the national system and using the updated National Egyptian Accreditation Guidelines awarded through the national accreditation body for healthcare services. Accreditation certification is a requirement for contractual eligibility under the new CHIS. Of the total DLI amount, 80% of the DLI payment will be paid against PHCs passing the QSI composite level indicators and 20% will be awarded for those PHCs further achieving the accreditation status. Each of the 600 targeted PHCs will undergo this entire process once and some of these facilities may require re-accreditation if they achieve the targets early. However, the process for reaching the 600 PHCs will be carried out in stages with batches of facilities passing the targets each year.

27. **Sub-component 1.2: Strengthen community health worker (CHW) program (US\$8.5 million).** This sub-component will finance results linked to strengthening the CHW program to improve health promotion and health education and thereby increasing overall awareness of the public about key health risks and prevention measures. CHWs will provide services using digital tools to deliver real time advice including referrals to higher levels of care. Intervention areas include maternal and child health (MCH), nutrition, encouraging the uptake of family planning, gender-based violence, awareness about NCDs and Hepatitis C, as well as early childhood development at the household level. DLI 5 will be used to finance results under this sub-component, as follows.

29. **DLI 5: Increased public awareness on key health risks and prevention measures (US\$3 million).** This will support improvements achieved at the district level through a strengthened CHW program focusing on better health promotion and health education messaging. Household surveys conducted in years 3, 4 and 5 will measure increased awareness of the population in the 9 targeted governorates as a result of CHW consultations on topics related to Family Planning, Nutrition, Gender-Based Violence and Hepatitis C.

30. This sub-component will also finance, through the regular IPF financing modality, the following activities: (a) contracting additional 600 CHWs in project target governorates to supplement the gaps for the project duration – these CHWs will be retained by Government subsequently through budget financing as it is the Government intention to gradually close the existing gap in the availability of CHWs, with this project providing a portion of the needed number of CHWs; (b) training for approximately 2,800 CHWs as per the new guidelines developed under the new CHW strategy (2017); (c) procuring 2,800 mobile tablet devices that would enable the CHWs to automate their messages, communicate with their supervisors, capture real time performance data, and provide instant feedback to queries raised by the community.

31. **Sub-component 1.3: Supporting health and family planning activities (US\$35.1 million).** This sub-component will be financed using the DLI modality as well as a traditional IPF approach building on the successful lessons to promote healthy families as well as family planning under the previous project which supported the 9 Governorates in Upper Egypt. This sub-component will expand the scope of those interventions on a national scale to bridge the unmet needs for such activities in Egypt as discussed in the Context section above, with a focus on addressing both supply and demand-side issues. These interventions will include: (i) provision of institutional capacity strengthening and technical support for the National Population Council to better manage population growth and characteristics; (ii) conduct research activities to further strengthen population programs; (iii) contracting 500 family planning doctors to fill gaps in the provision of culturally appropriate care; supporting yearly national communication campaigns to deliver family planning messages and strengthening media messaging in public spaces; (iv) strengthening the “Al-Wesam Initiative” by providing one-time performance payments to health facilities offering family planning services in accordance with WHO criteria; (v) supporting government supervisory visits to facilities; and (vi) procurement of select family planning methods and medical equipment (in complement with other donors and Government). These activities will particularly focus on PHCs in targeted areas with increasing total fertility, especially in rural areas and prioritizing poor households



capitalizing on the social safety net program (Takaful and Karama) which has nearly 1 million females in the child-bearing age. Implementation will utilize available local Civil Society Organizations (CSOs) to complement public capacities. This will be done in close coordination with the ongoing multi-year family planning programming by the EU through UNFPA and USAID focusing on procurement, training, and community outreach by community health workers, nurses, and providers. DLI 6 will be used to finance results under this sub-component, as follows.

32. **DLI 6: Increased contraceptive prevalence rate (US\$3.2 million).** This will incentivize improvements in the contraceptive prevalence rate on a national scale through greater focus on family planning at the PCH level and through the active engagement of family planning centers to promote long-term contraceptive use.

33. **Sub-component 1.4: Screening for Hep C and risk factors for high burden diseases (US\$134.3 million).** The sub-component will support nation-wide mass screenings for an estimated 35 million people for Hep C and further 20 million people for blood sugar level, blood pressure level, and Body Mass Index (BMI) as calibrated by age groups and geographic disease burden areas. The screenings will use the following modalities: (a) Community screening where more than 900 mobile teams will be deployed according to a prespecified plan set at the district and governorate levels for the various rural villages and urban neighborhoods. Each team consists of smaller sub-teams that would spread in a manner to manner to obtain optimal coverage of the intended geographic target; (b) PHC and hospital levels where continuous screening services will be provided for all visitors and inpatients; and (c) Categorical screenings that would cater for either specific geographic concentrations e.g. factories, offices, etc. or events e.g.) festivals, sports events, etc. A community mobilization campaign will typically precede the screening target area to generate demand on the screening activities. This sub-component will be mainly supported by a DLI approach but also includes the procurement and use of 2000 mobile tablet devices for the mobile screening teams that would enable them to instantaneously capture, transmit and interact with the national MOHP screening system. This activity would be done using the regular IPF financing modality.

The following two DLIs will be used to achieve the results under this sub-component, as follows:

34. **DLI 7: NCD screening (US\$4 million).** This DLI will support screening of blood pressure, random blood glucose level and Body Mass index activities. The DLI disbursement will be linked to the achievement of results in terms of the number of people screened as per the screening and referral protocol outlined in the POM.

35. **DLI 8: Hepatitis C screening (US\$129.5 million).** This DLI will support screening of the Hepatitis C virus. The DLI disbursement will be linked to the achievement of results in terms of the number of people screened as per the protocol outlined in the POM. For those testing positives at the initial rapid screening, a confirmatory Polymerase Chain Reaction (PCR) test will be administered to provide for a higher degree of certainty in their infection status and subsequent eligibility for treatment.

36. **Component 2: Strengthen secondary level care (US\$274.6 million total estimated cost).** This component will strengthen the integration of services through enhancing procedures, logistics and operations that would empower hospitals to provide comprehensive quality services to the population residing in their catchment areas. Further, the component will finance the costs associated with accreditation activities as per the national accreditation guidelines for hospitals. The component will also enhance activities aiming at maintaining safe blood supply to the population to cut back on one of the highest sources of viral infection for Hep C. Lastly, the component will finance the costs associated with medical treatment of Hepatitis C patients. While the majority of the funds under this component will be disbursed using regular IPF processes given the nature of the investments required, this component includes 1 DLI (#8) to



incentivize confirmation testing post treatment. This component will support the following sub-components:

37. **Sub-component 2.1: Providing for quality services at hospitals (US\$94 million).** The goal will be to improve the quality of services in 24 referral hospitals (general and district hospitals) in the target 9 governorates. This sub-component will strengthen the continuity of quality care for patients treated at PHCs. Further, an emphasis on the quality of direct clinical care will be made and checked regularly through direct independent observational tool (scorecard). The accreditation will be carried out in accordance with the national 2013 Egyptian Accreditation Guidelines for hospitals which puts a substantial emphasis on measuring functionality in terms of process and outputs, as well as, measuring patient satisfaction with the provided services. The support will also make room for treatment of patients who have been screened for blood sugar and hypertension under the project. As per the roll-out plan of the CSHIS, twenty-seven hospitals have been identified in 9 governorates under phases I, II & III of the roll-out plan representing the referral centers that are of urgent need for service quality enhancements. Through regular IPF support, the project proceeds will support hospitals with medical and non-medical equipment, medical and non-medical furniture, consumables, medicines, cleaning and safety personnel services, training of staff, and contracting needed capacities. Hospitals covered under the project will be encouraged to follow principles of self-autonomy during project implementation with direct oversight and hand-holding support provided from their respective GHDCs and the PMU. The POM will include detailed costed plans put forward by each hospital towards how it will implement activities that would improve the quality of services and achieve accreditation certification. The detailed procurement packages will be included in the annually updated project procurement plan.

38. **Sub-component 2.2: Improve the blood bank network (US\$50 million).** This will finance selected investments needed to ensure safe blood supply at all public hospitals and facilities which comes as a major pillar in the national strategy for the elimination of Hepatitis C. The aim is to ensure nearly 1 million units of blood (60% of the national capacity overall) are, with a high degree of certainty, safe of most well-known infection agents (Hepatitis C, Hepatitis B, HIV and Syphilis). The MOHP affiliated National Blood Transfusion Services (NBTS) system will be supported in terms of:

- a) Supplementing and replacing the current fleet of specially adapted blood donation and transportation mobile vehicles. 30 new blood donations and 15 blood transportation vehicles will be procured to support the ailing existing fleet. This will help increase the number of new blood units collected (non-remunerated) as per needs.
- b) Extending the automated national blood banks networks into the last remaining 11 regional blood transfusion centers through supporting IT infrastructure and operability. This will ensure that all regional NBTS regional centers will be connected to the national network enabling the automated tracking of all blood units from the point of their collection to the point of their dispensing; which helps with: (i) elimination of human related error; (ii) electronic tracking of stocks; and (iii) provide data for management decision making in terms of qualitative, quantitative and geographic availability of blood units and components.
- c) Boosting the Nucleic Acid Testing (NAT) testing of all dispensed blood units. This is the industry's gold standard in ensuring that all dispensed blood units are free from major infective agents (especially viral). The NAT testing capacity will be strengthened by further supplying the regional and central NBTS centers with 23 NAT machines and their respective testing kits. Testing kits will be enough to process 1 million units of blood per year during project duration.

39. **Sub-component 2.3: Treatment of Hepatitis C (US\$130.6 million).** This sub-component will support the provision of treatment of an estimated 1.5 million patients, of an estimated 3-4 million total patients (depending on the number identified through screening). The government will finance remaining 1.5-2.5 million out of its own budget. Support will be provided towards the procurement and distribution of Direct Antiviral Agents (DAAs) included in the



treatment protocols approved by MOHP and aligned with WHO recommendations- any updates in treatment protocols will be pre-approved by WHO. Operational support (consumables, kits and administrative expenses) will also be provided to nearly 200 hepatitis C centers spread all over the country. These centers specialize in receiving patients who have tested positive in the initial screening tests (field or facility based) and who have also been confirmed for infection status using a suitable PCR testing methodology.

40. Hepatitis Centers, in collaboration with their respective GHDCs, will be directly responsible for procurement of the needed medicines according to the World Bank procurement guidelines, and as specified in the project procurement plan. Preference will be given to those medicines which exhibit the following, in order: (a) medicines registered and allowed for use in the local Egyptian market; (b) medicine receiving WHO certificate of pre-qualification for the finished product or at least the Active Pharmaceutical Ingredient used in product manufacturing; (c) product having a proven track record of safety and efficacy in the local Egyptian context as proved through a study supervised/conducted and approved by WHO; (d) medicines produced under strict Good Manufacturing Practices (GMP) standards that are aligned with those of WHO.

41. This sub-component will also support all public hospitals at the national level (700) by providing Hepatitis B immuno-globulin which helps to protect the at high risk groups from infection risks with Hepatitis B following a hazardous post-exposure incident for health personnel or to prevent vertical transmission of disease (mother to child) in pregnant mothers. With no available cure and a national prevalence rate of only 0.8%, the current focus is to reduce risk of exposure and administer post-exposure protection to the high-risk groups (excluding those below the age of 24 years who have been previously vaccinated through the national vaccination program).

42. **DLI 9: Increased confirmation testing post Hep C treatment (US\$2 million).** This DLI will track the percentage of patients taking the confirmation test following treatment for Hep C, of the total number treated under the project. This is critical to ensure that patients are confirmed as fully cured.

43. **Component 3: Institutional Capacity Building and Project Management (US\$8 million total estimated cost):** This component will support the following:

- i. **Project Management and Monitoring and Evaluation.** This will include support for the Project Management Unit (PMU), training for MOHP staff, contracting Independent Verification Agency (IVA) and Financial auditors. The support to the PMU will involve supervision activities, contracting of additional required staff to the PMU and costs of holding supplemental working groups.
- ii. **Institutional Strengthening.** To strengthen the institutional capacity of key relevant public-sector agencies, this component will provide selected technical assistance as well as research work on the roll-out of the Comprehensive Health Insurance System and various project activities. Specifically, the component will:
 - a) **Social Health Insurance.** Provide technical support activities, through contracting specialized technical consultancies to strengthen institutional capacity and support quantitative and qualitative analysis which will inform the three newly created organizations responsible for implementing the new CHIS, namely: (i) Payer organization; (ii) Public Provider organization; and (iii) Accreditation/Regulator organization.
 - b) Conduct three household surveys (year 3, year 4, and year 5) to assess the impact of the CHWs program on various health awareness programs e.g. Family Planning, Nutrition issues, Gender-Based Violence and Hepatitis C infection and control, etc.)



- c) Conduct five implementation research studies to evaluate different aspects of the national screening program for Hepatitis C and NCDs.
- d) Conduct a yearly average quality of clinical care assessment for both PHCs and referral hospitals through an independent direct observational methodology.
- e) Conduct 2 population surveys to measure improvement in the use of family planning methods, and changes in fertility-related indicators.
- f) Conduct a yearly patient satisfaction surveys to measure the progress of patient satisfaction in project target governorates as a result of project implementation activities.

iii. **An International Advisory Committee (IAC) on Hep C and NCDs, to be established to disseminate lessons from this project globally.** Given the significance of Egypt's role as a global leader in the fight against Hep C and size of the NCD risk factors screening, the IAC will be formed to include leading experts from countries facing significant Hep C challenges and development partners who will act as an advisory board to analyze the experience gained under this project and provide strategic and technical advice to inform other countries on lessons learned from Egypt's experience. The IAC will meet annually, and be chaired by the Minister of Health.

44. Component 4: Contingency Emergency and Response Component (CERC)- (US\$0 million): This component, with a provisional zero allocation, would allow for a quick reallocation of resources within the total project financing envelope to boost the country's response in the event of a national health emergency. If triggered, Bank procedures governed by OP 10.0, paragraphs 12-14, regarding "Projects in Situations of Urgent Need of Assistance or Capacity Constraints" would apply. There is a low to moderate probability that during the life of the project, Egypt would experience a natural or a man-made disaster, including a disease outbreak of high public importance or other health emergency. Triggers for the CERC will be clearly outlined in the POM acceptable to the World Bank. Disbursements will be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this Component will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made. A CERC operations manual will be included in the POM.

E. Implementation

Institutional and Implementation Arrangements

45. The MOHP will be the main implementing agency for the project and will house the Project Management Unit (PMU) that will be in charge of all day-to-day operations and coordination with all relevant agencies, governorates and districts. The PMU will also be responsible for overall fiduciary activities, documentation, procurement of goods as well as contracting consulting and non-consulting services, monitoring & evaluation and reporting to the MOHP and the World Bank on all aspects of project implementation. The PMU will include the Project Manager (who is presently an official of the MOHP), relevant staff of the MOHP responsible for the various parts of the project (including staff from the Minister's office, Primary Care, Hospitals, Preventive & Hep C, Financial and Administrative departments), and a number of external consultants who will assist the MOHP in areas of M&E, financial management, procurement, safeguards monitoring, verification of results, audits, and technical expertise to support the roll-out of the insurance system. A Ministerial Decree no. 142 (dated March 24, 2018) was issued to create the project specific PMU for project preparation and implementation period. As part of its responsibilities, the PMU will be preparing and submitting semi-annual progress reports to the Bank that, inter alia, provide detailed reporting on project progress by components, procurement, financial management, verification reports received from independent verification and environmental and social issues. In addition, an annual external audit, combining both technical and financial audit components, will



be conducted to ensure the appropriate use of funds and to monitor physical progress in the targeted activities and governorates. The detailed roles and responsibilities of the PMU staff will be detailed in the POM which the PMU is currently developing. This is expected to be completed as a Condition of by Loan effectiveness. The POM will be adjusted during implementation to reflect any changes made, either in design, implementation arrangements, or fiduciary oversight.

46. **A Steering Committee (SC) will be responsible for overall project stewardship and oversight.** The SC will be headed by the Minister of Health and Population. The SC will include representatives from: (i) sector heads of the Minister's cabinet, Primary Care, Hospitals, Preventive Sector and Family planning sectors (ii) representatives from ministries of International Cooperation and Finance; and (iii) PMU manager. It will be tasked with resolving serious implementation bottle-necks, reviewing implementation progress, deciding on policy-relevant issues and approving the planned activities for the following period. The SC will meet at least on a bi-yearly basis or whenever called upon by the PMU manager. The SC should have the final decision on project course adjustments after consultations with the Bank team. The exact duties and responsibilities of the SC will be detailed in the POM.

47. **International Advisory Committee (IAC) on HepC and NCDs.** The scale and impact of the project supported activities for screening and treatment of Hep C and screening for NCD risk factors are largely viewed as a global public good. The project is expected to yield substantial new evidence and lessons as well as having direct and indirect consequences on global prices of Hep C medicines and screening tools. Therefore, the project supported IAC will be co-chaired by the Minister of MOHP. The World Bank and WHO will be members, along with global experts and representatives from countries with high Hep C burdens. The IAC will meet annually. The IAD will serve as a platform for dialogue and will be tasked with the following: (i) providing advice to the project Steering Committee and the PMU on relevant updated evidence-based screening and treatment protocols; (ii) reviewing project generated evidence and its potential global implications; and (iii) advising on additional implementation research. All decisions and recommendations stemming from the IAC will be publicly disclosed.

48. **Governorate Health Directorates Committees (GHDCs) will be strengthened at the level of the respective Governorate Health Directorates targeted under the project.** These committees will be tasked with reviewing progress, providing DHOs and hospitals within their respective Governorates with the needed oversight, coordination and technical support during implementation period. The GHDCs include directorate level staff mirroring the respective sectors involved in project implementation. The GHDCs will meet monthly and will report to the MOHP and the PMU with project implementation progress and decisions. The composition and the TOR of the GHDCs will be described in the POM.

49. **The District Health Offices (DHOs) will be responsible for direct control of implementation for its affiliated PHCs and related community-based activities.** Adequate fiduciary training will be supported under component 1 of the project to serve this purpose. Hospitals included under the project will enjoy full autonomy for project related activities with direct reporting to their relevant GHDCs and PMU. The National Blood Bank Transfusion Services (NBTS) will be responsible for project activities implemented within the central and peripheral affiliated regional blood transfusion centers for all financial, procurement and administrative activities.

50. **Screening activities will be carried out in different modalities.** Nationwide screenings for Hepatitis C and NCDs will be carried out through: (1) Mobile teams at the village and neighborhood levels, whereby each team will have a suitable number of sub-teams that spread to cover the geographical area of intended village and/or neighborhood using rapid tests; (2) PHC and hospital levels whereby is fixed and is offered in a continuous basis using either rapid or lab based testing; and (3) Targeted campaigns for remote areas, categorical groups (e.g. factories, office complexes, etc.).



The detailed screening plans, team compositions, tests used will be described in detail in the POM.

51. **The World Bank will provide continuous implementation support.** The Bank team will provide regular supervision missions to ensure that the PDOs are met and that the Results Framework and independent verification of DLIs are adequately measured. Further, the Bank team based in Cairo will be providing support on various project aspects especially on technical, safeguards and fiduciary issues.

52. **Citizen engagement is embedded in the project design and will be implemented through:** (i) gender differentiated consultations; (ii) mechanisms to assess patient satisfaction; (iii) the establishment and/or strengthening of grievance redress mechanisms (GRM); and, (iv) the dissemination of a patient's rights charter and citizen charters (publicized service standards) at various levels. Several consultations will be carried out at primary and secondary healthcare facilities, with both service providers and service users, and sectoral NGOs. Mechanisms such as citizen satisfaction surveys will be used to monitor service delivery performance and implement corrective measures for service failures. The MOHP has an existing GRM, building on prior activities financed under the recently closed Healthcare Quality Improvement Project. While the MOHP has a system in place, its effectiveness varies widely across governorates and levels. The existing GRM system will be strengthened through the roll-out of a User's Guide with standardized procedures and forms, and will include training for frontline staff.

53. **Follow-up consultations will be conducted during project implementation.** These mechanisms will primarily help communicate the needs of patients, staff, officials, and other stakeholders to the relevant levels of the MOHP for review and action. Additional activities supported by the project, particularly for provision of data on primary and secondary healthcare facilities, are expected to further enhance participation of, and accountability to, health system stakeholders. How feedback will be analyzed and considered in the government program will be agreed upon during project preparation. Since citizen engagement and participation of project beneficiaries are crucial to the success of the program, one of the indicators under the Quality of Services Index (QSI) list is linked to stakeholder participation and grievances.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

Environmental: The Project will be implemented in all governorates in Egypt, more details on the physical characteristics will be provided at a later stage. The Project risk is considered moderate and the environmental Category is rated as "B". OP 4.01 is triggered as the project will include minor infrastructure refurbishment, at first level of care and the provision of medical consumables and thus generation of medical waste. Environmental impacts of such activities are expected to be site-specific, limited and mitigatable. An Environmental and Social Management Framework (ESMF), including a Medical Waste Management Plan for health care facilities, will be required to be prepared by the MOPH. The Ministry has already started the assessment and the Bank team will consult with the ministry staff on the draft ESMF during the preparation mission and the final ESMF will be disclosed in-country and on the World Bank external website by Project Appraisal. Social: The project is expected to deliver substantial positive social outcomes for more than 40 million people through accreditation of primary health care units, screening of 30 million citizens for Hep C, administering treatment for estimated 2.5 million people, as well as screening



of 10 million citizens for NCDs. The proposed project will not require land acquisition as only indoor rehabilitation is envisioned. As such, land acquisition will not be required, and therefore no social safeguards policies will be triggered. Safety issues associated with the handling of waste by health unit staff, waste management staff, and communities will need to be prevented and mitigated. Possible associated risks with the program are concerns regarding cost and satisfaction of service.

G. Environmental and Social Safeguards Specialists on the Team

Mariana T. Felicio, Social Safeguards Specialist

Amal Nabil Faltas Bastorous, Social Safeguards Specialist

Amer Abdulwahab Ali Al-Ghorbany, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

| Safeguard Policies | Triggered? | Explanation (Optional) |
|-------------------------------------|------------|--|
| Environmental Assessment OP/BP 4.01 | Yes | <p>The project is considered as a Category B. OP 4.01 is triggered as the project will include under Component 2 minor infrastructure refurbishment, at first level of care and provision of medical consumables and thus generate medical waste.</p> <p>To ensure proper management of environmental impacts that might result from the implementation of the Project's interventions, an Environmental and Social Management Framework (ESMF), including a Medical Waste Management Plan for health care facilities, is being prepared by the MOPH. Based on the guidance provided in the ESMF, a site-specific Environmental Management Plan (EMP) will be prepared prior to procurement of works for each sub-project that includes infrastructure refurbishment. In most cases, the works are expected to be limited to minor rehabilitation, and the Bank's standard Checklist ESMP will be used. The project will provide clear environmental management guidelines and training, as deemed necessary, for contractors hired for rehabilitation and outfitting of health care facilities. Attention will be paid to medical waste, waste generated at</p> |



| | | |
|--|----|---|
| | | construction sites and health and safety aspects of public as well as health care providers |
| Performance Standards for Private Sector Activities OP/BP 4.03 | No | Policy is not triggered. The project will be implemented by MoHP |
| Natural Habitats OP/BP 4.04 | No | Policy is not triggered as the project will not intervene in areas of natural habitat nor result in loss, conversion or degradation of natural habitats or critical natural habitats as defined by the policy |
| Forests OP/BP 4.36 | No | Policy does not apply as the project will not be implemented in any forested areas. |
| Pest Management OP 4.09 | No | Policy does not apply as the project will not support the purchase or use of pesticides or pesticide application equipment. |
| Physical Cultural Resources OP/BP 4.11 | No | Policy is not triggered as the project will not involve any activities that might impact or are located in areas of cultural heritage sites. |
| Indigenous Peoples OP/BP 4.10 | No | Policy is not triggered as indigenous people as defined in the policy are not present in project areas. |
| Involuntary Resettlement OP/BP 4.12 | No | Policy is not triggered as works will only involve rehabilitation in the existing clinics and no new construction and/or land acquisition will be required. |
| Safety of Dams OP/BP 4.37 | No | Policy is not triggered as the project will not include construction of dams as defined by the policy and as none of the investments under this project depends on the performance of existing dams. |
| Projects on International Waterways OP/BP 7.50 | No | Policy is not triggered as the project will not undertake any activities in the catchment areas of international waterways and shared aquifers. |
| Projects in Disputed Areas OP/BP 7.60 | No | Policy is not triggered as project activities will not be implemented in any disputed areas. |

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:



3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The project is considered as a Category B. OP 4.01 is triggered as the project will include under Component 2 minor infrastructure refurbishment, at first level of care and provision of medical consumables and thus generate medical waste.

To ensure proper management of environmental impacts that might result from the implementation of the Project's interventions, an Environmental and Social Management Framework (ESMF), including a Medical Waste Management Plan for health care facilities, is being prepared by the MOPH. The ESMF will include, inter alia, summary of all environmental and social related impacts that might result from the proposed accreditation standards for health facilities and measures suggested in the accreditation guidelines to mitigate these impacts. Similarly, a section in the ESMF will be included for the CERC and impact/risk management of any activity under this component. Furthermore, and based on the guidance provided in the ESMF, a site-specific Environmental Management Plan (ESMP) will be prepared prior to procurement of works for each sub-project that includes infrastructure refurbishment. In most cases, the works are expected to be limited to minor rehabilitation, and the Bank's standard Checklist ESMP will be used. The project will provide clear environmental management guidelines and training, as deemed necessary, for contractors hired for rehabilitation and outfitting of health care facilities. Attention will be paid to medical waste, waste generated at construction sites and health and safety aspects of public as well as health care providers.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

| | | |
|--|--|--|
| Date of receipt by the Bank 10-Apr-2018 | Date of submission for disclosure 24-Apr-2018 | For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors |
|--|--|--|

"In country" Disclosure
Egypt, Arab Republic of
26-Apr-2018

Comments

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)



OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

NA

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

NA

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

NA

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

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APPROVAL

| | |
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| Task Team Leader(s): | Amr Elshalakani |
|----------------------|-----------------|

Approved By

| | | |
|---------------------------|-------------------|-------------|
| Safeguards Advisor: | | |
| Practice Manager/Manager: | Ernest E. Massiah | 02-May-2018 |
| Country Director: | Asad Alam | 03-May-2018 |